Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

TN 96-015
STATE PLAN AMENDMENT
INPATIENT ACUTE HOSPITAL

EXHIBIT 6: 114.1 CMR 36.09(3)(c) and (d).

36.09: continued

(k) Maternity/Newborn Rates Delivery related maternity cases are paid on the standard payment amount per discharge (SPAD) basis with one SPAD paid for the mother and one SPAD paid for the newborn. The rate includes payment for all services except physician services provided in conjunction with a maternity stay, including but not limited to follow-up home visits provided as incentives for short delivery stays. There are no additional payments to the hospitals or to other entities, such as Visiting Nurse Associations or home health agencies, for providing services in collaboration with the hospital. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payer.

(3) Outlier rates of payments.

(a) Eligibility. An outlier *per diem* payment is added to the standard payment amount per discharge for a particular patient if all of the following conditions are met:

1. the length of stay exceeds 20 cumulative acute days (not including days in a distinct part psychiatric unit);
2. the hospital has fulfilled its discharge planning duties as required by 130 CMR (Division of Medical Assistance regulations);
3. the patient continues to need acute level care and is therefore not on administrative day status on any day for which outlier payment is claimed;
4. the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed.
5. the patient is not a patient in a chronic unit, as defined in 114.1 CMR 36.09(7)(a), for which a chronic *per diem* has been established pursuant to 114.1 CMR 36.09(7).

(b) The outlier *per diem* payment amount is equal to 55% of the statewide standard payment amount per day multiplied by the hospital's wage area index and Medicaid casemix index, plus a *per diem* payment for the hospital's pass-through costs, direct medical education, and reasonable capital costs. The statewide standard payment amount per day is equal to the statewide standard payment amount per discharge divided by the statewide average FY95 all payer length of stay. The pass-through, direct medical education and reasonable capital cost *per diem* payments are equal to the per discharge amount for each of the components divided by the hospital's Medicaid length of stay.

(c) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual pediatric outlier adjustment is made to acute care hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for children greater than one year of age and less than six years of age. Only hospitals that meet the Basic Federally-Mandated Disproportionate Share eligibility per 114.1 CMR 36.09(10)(b) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.
2. Eligibility is determined by the Division as follows:

a. Exceptionally long lengths of stay: First, calculate a statewide weighted average Medicaid inpatient length of stay. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stay. Third, multiply the statewide weighted standard deviation for Medicaid inpatient length of stay by two and add that amount to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:

i. First, calculate the average cost per Medicaid inpatient discharge for each hospital.

ii. Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.

36.09: continued

iii. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. Eligibility for an Outlier Adjustment in the Payment Amount. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:

i. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.09(3)(c)2.a., then the hospital is eligible for an outlier adjustment in the payment amount.

ii. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.09(3)(c)2.b., then the hospital is eligible for an outlier adjustment in the payment amount.

iii. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.09, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.09(10)(b)5. The total funds allocated for payment to acute hospitals under 114.1 CMR 36.09(10)(b)(5) are reduced by the payment amount under 114.1 CMR 36.09.

(d) Infant Outlier Payment In accordance with 42 U.S.C. 1396a(s), an annual infant outlier payment adjustment is made to hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

a. Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated.

The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

b. Exceptionally High Cost is calculated for hospitals providing services to infants under one year of age by the Division as follows:

i. First, the average cost per Medicaid inpatient case for each hospital is calculated;

ii. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;

iii. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two, and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. Eligibility for an Outlier Adjustment in the Payment Amount. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.09(3)(d)2.a., then the hospital is eligible for an outlier adjustment in the payment amount.

Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.09(3)(d)2.b. above, then the hospital is eligible for an outlier adjustment in the payment amount.

36.09: continued

d. Payment to Hospitals. Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of $50,000. For example, if two hospitals qualify for an outlier adjustment, each receives $25,000.

(4) Rates of payments for transfer patients. 114.1 CMR 36.09(4) applies to payments for patients transferred from one acute hospital to another and for patients transferred between units within a hospital..

(a) Transfers between hospitals.

1. Payments for patients transferred from one acute hospital to another are made on a *per diem* basis capped at the standard payment amount per discharge for the hospital that is transferring the patient.

2. The transfer *per diem* payment amount is equal to the statewide standard payment amount per day, multiplied by the transferring hospital's Medicaid casemix index derived from paid claims between June 1, 1995 and May 31, 1996 and wage area index, plus pass-through, direct medical education, and reasonable capital costs *per diem* payments. The standard payment amount per day is derived by dividing the statewide standard payment amount per discharge by the FY95 average all-payer length of stay. The pass-through, direct medical education, and reasonable capital cost *per diem* payments equal the hospital's pass-through costs, direct medical education costs, and reasonable capital costs per discharge divided by the hospital's Medicaid length of stay.

3. The rate of payment for the hospital that is receiving the patient is the standard payment per discharge basis, in accordance with the methodology specified in 114.1 CMR 36.09(2), if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital is paid at the hospital specific transfer *per diem* rate up to the hospital specific per discharge amount ("back transferring"). Additionally, "back transferring" hospitals are eligible for outlier payments specified in 114.1 CMR 36.09(3).

4. An acute care hospital receiving a patient from a DMH Replacement Unit within another acute care hospital is paid at its standard payment amount per discharge. DMH Replacement Unit rates are governed by a separate contract between the hospital provider, the Division and the Division of Medical Assistance.

5. Payment amounts may vary depending on the managed care status of the recipient and the network status of the hospital. An emergency admission of a managed care patient in a non-network hospital is paid by the Division of Medical Assistance MH\SA provider at the rate for psychiatric and substance abuse services pursuant to 114.1 CMR 36.09(6), if the hospital follows authorization procedures outlined in 106 CMR 450.125. The specific applicable payments for particular circumstances are set forth in 114.1 CMR 36.09(4)(a)5.a:

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EXHIBIT 7: 114.1 CMR 36.09(10).

(u) Therapy Services. Hospitals are reimbursed for physical, occupational, or speech/language therapy services according to both the Therapist Regulations in 130 CMR 432.000 and the cost to charge ratio or the hospital's usual and customary charges, whichever is lower.

(9) Rates of Payment for Emergency Services at Non-Contracting Hospitals. 114.1 CMR 36.09(9) establishes rates of payment to acute care hospitals who have not signed a contract with the Division of Medical Assistance. Rates of payment for all emergency services and continuing emergency care provided in an acute hospital to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395 (dd), are as follows:

(a) Rates of payment for emergency services provided in clinics, emergency rooms or trauma centers are established according to the methodology set forth in 114.1 CMR 36.09(8)(a), (8)(b) and (8)(c).

(b) Rates of payment for emergency radiology and ambulatory services are established according to the methodology set forth in 114.1 CMR 36.09(8)(d).

(c) Rates of payment for emergency laboratory and ancillary services are established according to the methodology set forth in 114.1 CMR 36.09(8)(e) and (8)(f).

(d) Rates of payment for emergency services provided by ambulance services are established according to the methodology set forth in 114.1 CMR 36.09(8)(g).

(e) Rates of payment for emergency dialysis services are established according to the methodology set forth in 114.1 CMR 36.09(8)(h).

(f) Rates of payment for emergency psychiatric day treatment are established according to the methodology set forth in 114.1 CMR 36.09(8)(i).

(g) Rates of payment for emergency dental services are established according to the methodology set forth in 114.1 CMR 36.09(8)(j).

(h) Payment for emergency inpatient admissions is made using the transfer *per diem* rate of payment, established according to the methodology set forth in 114.1 CMR 36.09(4), up to the hospital-specific standard payment amount per discharge, established according to the methodology set forth in 114.1 CMR 36.09(2). If the data sources specified in 114.1 CMR 36.09 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.09, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates. Hospitals must notify the Division of Medical Assistance within 24 hours of admitting a Medicaid beneficiary in order to be eligible for payment pursuant to 114.1 CMR 36.09(9).

(i) Rates of payment for emergency recovery and observation bed services are established according to the methodology set forth in 114.1 CMR 36.09(8)(q).

(j) Rates of payment for emergency operating room and surgical room services are established according to the methodology set forth in 114.1 CMR 36.09(8)(r).

(k) Rates of payment for emergency services provided by a hospital-based physician are established according to the methodology set forth in 114.1 CMR 36.09(8)(p).

(l) Rates of payment for emergency services related to the Norplant System are established according to the methodology set forth in 114.1 CMR 36.09(8)(s).

(10) Classifications of Disproportionate Share Hospitals (DSHs) and Payment Adjustments The Medicaid program assists hospitals that carry a disproportionate financial burden of caring for the uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid makes an additional payment adjustment above the rates established under 114.1 CMR 36.09(10) to hospitals which qualify for such an adjustment under any one or more of the following classifications. Only hospitals that have an executed contract with the Division of Medical Assistance are eligible for disproportionate share payments. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments are described in 114.1 CMR 36.09(10). Medicaid payment adjustments for disproportionate share contribute toward funding of allowable uncompensated care costs.

36.09: continued

When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment is determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following DSH classifications (114.1 CMR 36.09 (10)). If a hospital's Medicaid contract is terminated, any adjustment is prorated for the portion of the year during which it had a contract, the remaining funds it would have received are apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals are informed if an adjustment amount changes due to reapportionment among the qualified group and told how overpayments or underpayments by the Division of Medical Assistance are handled at that time.

To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.09(10), a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.09(10) a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%.

Effective October 1, 1995 the total amount of DSH payment adjustments awarded to a particular hospital under 114.1 CMR 36.09(10) does not exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, except as provided at 42 U.S.C. § 1396r-4(g).

(a) High Public Payer Hospitals: Disproportionate Share Status under M.G.L. 118G.

1. Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.10 are eligible for this adjustment.
2. Calculation of Adjustment.
   a. The Division of Medical Assistance allocates $11.7 million for this payment adjustment.
   b. The Division then calculates for eligible hospitals the ratio of their allowable free care charges, as defined in M.G.L. c. 118G, to total charges. Free care charge data will be obtained from the hospital's prior year filing of the Division's uncompensated care reporting form.
   c. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.09(10)(a)2.b.
   d. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.09(10)(a)2.b.
   e. Hospitals who meet or exceed the 75th percentile qualify for a High Public Payer Hospitals Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.1 CMR 36.07 to determine allowable free care costs.
   f. The Division then determines the sum of the amounts determined in 114.1 CMR 36.09(10)(a)2.e for all hospitals that qualify for a High Public Payer adjustment.
   g. Each hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.09(10)(a)2.a. multiplied by the amount determined in 114.1 CMR 36.09(10)(a)2.e. and divided by the amount determined in 114.1 CMR 36.09(10)(a)2.f.

(b) Basic Federally - Mandated Disproportionate Share Adjustment.

1. The Division determines a federally-mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the federally-mandated Medicaid disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.
   a. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form..
   b. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

36.09: continued

2. The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the federally-mandated disproportionate share adjustment. The Division determines such threshold as follows:

a. First, calculate the statewide weighted average Medicaid inpatient utilization rate. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.

b. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

c. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

d. The Division then calculates each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.09(10)(b)2.c., then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

3. The Division then calculates each hospital's low-income utilization rate as follows:

a. First, calculate the Medicaid and subsidy share of gross revenues according to the following formula:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

b. Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.

c. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.09(10)(b)3.a. to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.09(10)(b)(3)b. If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated disproportionate share adjustment under the low-income utilization rate method.

4. Payment Methodology. The payment under the federally-mandated disproportionate share adjustment requirement is calculated as follows:

a. For each hospital deemed eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 36.09(10)(b), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.09(10)(b)2.d. by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.09(10)(b)2.c. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

b. For each hospital deemed eligible for the basic federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The ratio resulting from such division is the federally-mandated Medicaid disproportionate share ratio.

c. The Division then determines, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.09(10)(b)4.a. and 114.1 CMR 36.09(10)(b)4.b.

d. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.09(10)(b)5. by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 36.09(10)(b)4.c.

36.09: continued

e. The Division then multiplies the minimum payment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 36.09(10)(b)4.a. and b. The product of such multiplication is the payment under the federally-mandated disproportionate share adjustment requirement. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean, in accordance with 42 U.S.C. § 1396r-4.

5. The total amount of funds allocated for payment to acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement is $200,000 per year. These amounts are paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.09(10)(b)4.e.

(c) Disproportionate Share Adjustment for Safety Net Providers. The Division determines a disproportionate share safety net adjustment factor for all eligible hospitals, using the data and methodology described in 114.1 CMR 36.09(10)(c)1. through 3..

1. Data Sources. The Division uses free care charge data from the prior year's filing of the Division's UC-9x report and total charges from the RSC-403. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

2. Eligibility of Disproportionate Share Hospitals for the Safety Net Provider Adjustment. The disproportionate share adjustment for safety net providers is an additional payment for hospitals which meet the following criteria:

a. is a public hospital or a public service hospital as defined in 114.1 CMR 36.09(2)(j)3.;

b. has a volume of Medicaid and free care charges in FY93, or for any new hospital, in the base year as determined by the Division of Health Care Finance and Policy which is at least 15% of its total charges;

c. is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, or indigent or uninsured patients;

d. has completed an agreement with or is the specified beneficiary of an agreement with the Division of Medical Assistance for intergovernmental transfer of funds, as defined in federal regulations governing state financial participation as a condition of federal reimbursement, to the Medicaid program for the disproportionate share adjustment for safety net providers;

e. is the subject of an appropriation requiring an intergovernmental transfer.

3. Payment to Hospitals under the Adjustment for Safety Net Providers. The Division calculates an adjustment for hospitals which are eligible for the safety net provider adjustment, pursuant to 114.1 CMR 36.09(10)(c)2. This adjustment shall be reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under Title XIX, or to low-income patients, and equals the amount of funds specified in an agreement between the Division of Medical Assistance and relevant governmental unit. The disproportionate share adjustment for safety net providers isnot in effect for any rate year in which Federal Financial Participation under Title XIX is unavailable for this payment.

(d) Uncompensated Care Disproportionate Share Adjustment Hospitals eligible for this adjustment are those that report "free care costs," as defined by 114.6 CMR 7.00 and who are participating in the free care pool administered by the Division pursuant to M.G.L. c. 118G. The payment amounts for eligible hospitals are determined by the Division in accordance with its regulations at 114.6 CMR 7.00. These payments are made to eligible hospitals in accordance with Division's regulations and the ISA between the Division of Medical Assistance and the Division of Health Care Finance and Policy. Eligible hospitals receive these payments on a periodic basis during the term of their Medicaid contract with the Division.

36.09: continued

(e) Commonhealth Program Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those that provide hospital services pursuant to the Commonwealth program to low-income disabled individuals who are covered by a wholly state-financed program of medical assistance of the Division of Medical Assistance, as defined in regulations of the Division of Medical Assistance at 130 CMR 490.000 and 130 CMR 510.000 through 515.000. The payment amounts for eligible hospitals receiving payments pursuant to the Commonhealth program are determined and paid on a periodic basis by the Division of Medical Assistance in accordance with 130 CMR 490.000 and 130 CMR 501.000 through 515.000.

(f) Medical Security Low-Income Unemployment Disproportionate Share Adjustment. Hospitals eligible for this adjustment are those acute hospitals that provide hospital services to low-income unemployed individuals who are uninsured or are covered only by a wholly state-financed program of medical assistance of the Department of Employment and Training, in accordance with regulations of the Department of Employment and Training at 114.6 CMR 9.00. The payment amounts for eligible hospitals participating in the Medical Security plan are determined and paid by the Department of Employment and Training in accordance with 114.6 CMR 9.00 and the ISA between the Department of Employment and Training and the Division of Medical Assistance.

(11) Data Sources. The following data sources are used in the development of the Medicaid rates. The FY95 RSC-403 cost report is used to develop the pass through amounts (with the exception of capital) and the base cost per discharge. Capital pass throughs and the wage area index are calculated from the HCFA-2552 Medicare Cost report. All payor casemix indices are calculated using the New York weights, version 12 New York Grouper. Medicaid casemix indices are calculated using the paid claims database for the time frame specified in 114.1 CMR 36.09

(12) Upper Limit Review and Federal Approval. Medicaid rates of payment calculated under the provisions of 114.1 CMR 36.09(12) conform to the upper limit requirement imposed by Title XIX of the Social Security Act. That is, the federal government requires that states certify that inpatient hospital payments in the aggregate do not exceed the amount of payments that would result if payments were based on the Medicare principles (TEFRA). Rates of payment established pursuant 114.1 CMR 36.09(12) are adjusted if it is determined that aggregate payments exceed this limit or if adjustments are required by the Health Care Financing Administration (HCFA).

(13) Hospital Mergers and New Hospitals.

(a) Hospital Mergers. For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the hospital during the fiscal year, the Division may have to make adjustments to the hospitals' rates. The Division will determine the best available data source(s) for these adjustments.

(b) New Hospitals. The rates of reimbursement for new hospitals shall be determined in accordance with the provisions of 114.1 CMR 36.09 to the extent the Division deems possible. If the data sources specified in 114.1 CMR 36.09 are not available, or if other factors do not permit precise conformity with the provisions of 114.1 CMR 36.09, the Division will select such substitute data sources that the Division deems appropriate in determining hospitals' rates.

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State Plan Under Title XIX of the Social Security Act
State: Massachusetts
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EXHIBIT 8: 114.6 CMR 7.00

effective 12/1/96

114.6 CMR 7.00: ADMINISTRATION OF ACUTE HOSPITAL UNCOMPENSATED CARE POOL AND CRITERIA FOR CREDIT AND COLLECTION POLICIES UNDER M.G.L. c. 118G

Section

7.01: General Provisions

(1) Scope, Purpose and Effective Date.

(a) 114.6 CMR 7.00 implements the provisions of M.G.L. c. 118G, regarding the acute hospital uncompensated care pool.

(b) The purpose of 114.6 CMR 7.00 is to specify:

1. The rules which will govern payment by hospitals to the pool and payment by the pool to hospitals.
2. The procedures that acute care hospitals must follow regarding the acquisition and verification of patients' financial resource information for determination of patients' ability to pay for hospital care provided and/or to be provided.
3. The criteria that acute care hospitals must meet regarding notification of the availability of free care and public assistance programs to patients.
4. The criteria that acute care hospitals' credit and collection policies must meet regarding bad debt and free care accounts. This shall include, the standards for reasonable collection effort of bad debt accounts; the standards for determining free care accounts; and the standards for documenting bad debt and free care accounts.

(2) Authority: 114.6 CMR 7.00 is adopted pursuant to M.G.L. c. 118G and St. 1995, c. 38.

(3) Organization: 114.6 CMR 7.00 is divided into sections. Each section may be further divided into subsections designated by arabic numerals enclosed in parentheses. A subsection may be segregated into divisions, designated by letters enclosed in parentheses. A division may be further segregated into subdivisions designated by arabic numerals followed by a period.

7.02: Definitions

Actual Costs. All direct and indirect costs incurred by a hospital or a community health center in providing medically necessary care and treatment to its patients, in accordance with generally accepted accounting principles.

Acute Hospital. Any hospital licensed under M.G.L. c. 111, § 51 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Allowable Free Care Costs. The total free care charges of a hospital multiplied by its cost-to-charge ratio.

7.02: continued

Bad Debt. An account receivable based on services furnished to any patient which:
(a) is regarded as uncollectible, following reasonable collection efforts, pursuant to the hospital's credit and collection policies and procedures;
(b) is charged as a credit loss pursuant to the hospital's credit and collection policies and procedures;
(c) is not the obligation of any governmental unit of the federal or state government or agency thereof; and
(d) is not free care.

Charge. The uniform price for each specific service within a revenue center of an acute hospital established in accordance with M.G.L. c. 6B, § 7.

Children's Medical Security Plan. A program of primary and preventive pediatric health care services for certain children, from birth to age 13, administered by the Department of Employment and Training pursuant to M.G.L. c. 118G, § 17A.

Collection Action. Any activity by which a hospital or its designated agent requests payment for services from a patient or a patient's guarantor. A collection action of a hospital shall include those activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commission. The Rate Setting Commission established under M.G.L. c. 6A, § 32., now the Division of Health Care Finance and Policy.

Compliance Liability. Pursuant to St. 1991, c. 495, § 56, hospitals which over generated approved revenues under St. 1988, c. 23 are required to pay a portion of such excess revenue into the Uncompensated Care Trust Fund established under M.G.L. c. 118G,. For the purpose of 114.6 CMR 7.00, the payment of such excess revenue shall be referred to as a hospital's "Compliance Liability." The Division is responsible for determining each hospital's Compliance Liability which covers hospital fiscal years 1988 through 1991.

Cost-to-Charge Ratio. A calculation to be used by the Division of Health Care Finance and Policy in determining the uncompensated care pool's liability to each hospital in accordance with M.G.L. c. 118G.

Credit and Collection Policy. The hospital's policy, as expressed in a statement of general principles approved by its governing board, guiding the management of the hospital's billing and collection of accounts receivable, and the hospital's procedures, as expressed in an operating plan to implement such policy, with respect to:
(a) the effort the hospital makes to collect payment for services;
(b) the criteria the hospital uses to assign uncollectibles to bad debt account; and
(c) the criteria the hospital uses for the provision of free care. The credit and collection policy shall include, as a minimum, the methods the hospital uses, the practices it follows and the forms or schedules it adopts in order to comply with the Division's criteria and standards for credit and collection policy as set forth in 114.6 CMR 7.00.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Disproportionate Share Hospital. Any acute hospital that exhibits a payer mix where a minimum of 63% of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care.

Emergency Aid to the Elderly, Disabled and Children (EAEDC) Patient. A patient who is a recipient of governmental benefits under M.G.L. c. 117A *et seq.*

7.02: continued

Emergency Care. Emergency care shall include hospital services provided after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain in which the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part, examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd). In order to qualify as emergency care, services must be medically necessary services and must be:

(a) determined to be an emergency by a medical professional in charge of the patient, and are so classified in the patient's hospital record pursuant to hospital's manual or document described in 114.6 CMR 7.03(1)(b); or

(b) inpatient medical care services which are associated with and follow immediately the emergency care as described in 114.6 CMR 7.02(1); or

(c) screening of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify under 114.6 CMR 7.02(1), to the extent that such screening is required by law.

Exempt. Patients exempt from collection action include patients with approved free care applications and patients who are recipients of governmental benefits pursuant to 114.6 CMR 7.08(2)(a).

Family Income. Family income means gross family income and is the sum of annual earnings and cash benefits from whatever source family members receive before taxes.

Federal Poverty Income Guidelines. The Federal Poverty Income Guidelines used as an eligibility criterion by the federal Department of Health and Human Services.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year.

Free care. Any unpaid hospital charges for:

(a) emergency care to uninsured patients, for which the costs have not been collected after reasonable collection efforts; or

(b) medically necessary services to patients who are exempt from collection action pursuant to 114.6 CMR 7.08 and who have been deemed, pursuant to the hospital's credit and collection policy, financially unable to pay for all or part of the hospital care rendered to the patient; or

(c) medically necessary services to patients in situations of medical hardship where major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid; or

(d) unpaid Medicare deductibles, co-payments, and other unpaid charges for services rendered to participants in the Medicare program shall be deemed allowable free care charges eligible for payment from the pool to the extent that such charges:

1. satisfy the requirements of 114.6 CMR 7.02: Free care(a) or (b);

2. were properly submitted for payment to the Medicare intermediary and were rejected by such intermediary as failing Medicare substantive rules or such charges were rejected by the intermediary because the hospital has failed to follow the Federal collection rules, provided however, that the hospital has satisfied the collection requirements of 114.6 CMR 7.00. A hospital need not submit for payment to the Medicare intermediary any charges for services which can not be allowed for payment by such intermediary as a result of the operation of Federal law;

3. the hospital establishes that reasonable collection efforts were made pursuant to 114.6 CMR 7.02: Collection Action. Such collection efforts shall not include populations not requiring collection action pursuant to 114.6 CMR 7.08; or

7.02: continued

(e) services rendered to residents of foreign countries to the extent that:
1. such charges satisfy the requirements of 114.6 CMR 7.02: Free care(a) or (b);
2. the hospital had no reason to know that the patient was a resident of a foreign country; or
3. the hospital had reason to know that the patient was a resident of a foreign country and establishes through written documentation that it investigated whether the patient had foreign health care coverage and properly submitted a claim for payment to either:
a. the patient's foreign health insurance policy; or
b. to the appropriate foreign governmental health care program; or
c. appropriate embassy or nearest consulate.

(f) services rendered to victims of motor vehicle accidents to the extent that the hospital had reason to know that the patient's injury or illness resulted from a motor vehicle accident and establishes through written documentation, the following:
1. that it investigated whether the patient had a motor vehicle liability policy and where applicable, properly submitted a claim for payment to the patient's motor vehicle liability insurer; and
2. if the accident involved more than one motor vehicle, the hospital investigated whether the driver and/or owner of the other motor vehicles had motor vehicle liability policies and where applicable, properly submitted claims for payment to the motor vehicle liability insurers of the other drivers and/or owners;

(g) recovery of payments must be reported to the Division by a hospital which has received a recovery pursuant to its activities under 114.6 CMR 7.02: Free Care(d), (e) or (f). If the hospital claimed any payments from the uncompensated care pool for services subject to the terms of 114.6 CMR 7.02: Free Care, then such payments shall be offset against the pool liability to the hospital for the next payment cycle to the extent of such claim or recovery, whichever is lower.

Any unpaid Medicare charges and charges relating to residents of foreign countries and victims of motor vehicle accidents which do not meet the requirements under 114.6 CMR 7.02, shall not be considered allowable free care and shall be denied upon audit commencing with fiscal year 1996 and all fiscal years thereafter.

Gross Patient Service Revenue. The total dollar amount of hospital's charges for services rendered in the fiscal year.

Guarantor. A person or group of persons who assumes the responsibility of payment of (all or part of) the hospital charges for services, but not including third party payers.

Health Insurance Company. A company as defined in M.G.L. c. 175, § 1, which engages in the business of health insurance.

Health Insurance Plan. The medicare program or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

Health Maintenance Organization. Company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in M.G.L. c. 176G, § 1.

Healthy Start. A program of health care, designed to lower the infant mortality rate, administered by the Department of Public Health pursuant to M.G.L. [illegible]

Hospital. An acute hospital.

Hospital Service Corporation. A corporation established for the purpose of operating a nonprofit hospital service plan as provided in M.G.L. c. 176A.

Managed Health Care Plan. A health insurance plan which provides or arranges for, supervises and coordinates health care services to enrolled participants, including plans administered by health maintenance organizations and preferred provider organizations